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ALW CAR WORKSHOP SDN BHD v. AXA AFFIN GENERAL INSURANCE BHD

FEDERAL COURT, PUTRAJAYA
ZAHARAH IBRAHIM CJ (MALAYA)
DAVID WONG DAK WAH CJ (SABAH & SARAWAK)
B RAMLY ALI FCJ
BALIA YUSOF WAHI FCJ
ALIZATUL KHAIR OSMAN FCJ
[CIVIL APPEAL NO: 02(f)-1-01-2018(W)]
13 MAY 2019

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INSURANCE: *Fire insurance – Claim – Claim for losses under policy – Whether claim grossly exaggerated – Whether prima facie presumption arose that insured not acting in good faith – Whether insured intended to defraud insurer – Claim amended before commencement of trial to reflect losses assessed by adjuster – Whether* D *gave rise to inference that insured deliberately and intentionally inflated claim to deceive insurer – Whether intention to deceive established – Whether claim defeated – Whether insurer entitled to repudiate liability – Whether standard of proof on balance of probabilities – Contracts Act 1950, s. 17*

The appellant ('insured'), who owned and operated a car repair workshop, E had taken a fire insurance policy offered by the respondent ('insurer'), entitled 'Motor Repairers Protection Plan Policy' ('policy'), which took effect from 20 December 2012 to 19 December 2013. The policy provided, among others, insurance coverage in case of fire to the workshop with a maximum insured sum of RM1.4 million. On 21 May 2013, a fire broke out F at the workshop and destroyed the workshop and some of the insured items. The insured sought indemnity for the losses, under the policy, from the insurer. On 24 June 2013, the insured submitted a claim amounting to RM1,699,850 ('the first claim'). However, the following day, the insured submitted an amended claim to the insurer. The losses were not quantified. G Subsequently, on 9 July 2013, the insured submitted a revised claim amounting to RM1,712,560 for the losses and damages suffered due to the fire ('revised claim'). The insurer, by a letter dated 4 March 2014, repudiated liability on the grounds that the insured's claim had been grossly exaggerated and tainted with fraud. The insured thus, filed a claim against the insurer at the High Court. However, just before the commencement of the trial, with H leave of the court, the insured amended its statement of claim to include a claim for the sum of RM237,452.11 only for the total loss and damage suffered due to the fire to reflect the losses assessed by the adjuster appointed by the insurer. The High Court allowed the insured's claim and ordered the insurer to pay a sum of RM237,452.11. On appeal by the insurer, the Court I of Appeal reversed and set aside the decision of the High Court and held that the insurer was entitled to deny liability and repudiate the insurance policy

on the ground that the claim was exaggerated and fraudulent. The insured was thus granted leave to appeal to the Federal Court on the following questions: (i) where an insurance claim filed for a larger amount, and pleadings were amended to reduce the claim, in the absence of actual fraud, whether the insurer was still entitled to repudiate liability on the basis of an exaggerated claim; and (ii) where an allegation of an 'exaggerated/inflated claim', was made, whether the actual fraud (in the contractual sense) ought to be proven, in the usual way, by those who alleged it.

Held (dismissing appeal with costs)
Per Ramly Ali FCJ delivering the judgment of the court:

(1) The fire insurance policy, being a contract of insurance, was of a nature known as contract '*uberrimae fidei*', *ie*, a contract of fullest confidence. It required the highest standard of good faith between the parties. All parties concerned must deal in good faith, making a full declaration of all material facts, particularly in making an appropriate claim for loss and damage under the policy when an event of fire occurred. When an insured inflates or exaggerates his claim, there is a *prima facie* presumption that he is not acting in good faith and, it is for the insured to rebut the presumption if he is to succeed in his claim. The onus of showing that a claim is fraudulent lies with the insurer. The mere fact that a claim was exaggerated or inflated does not necessarily mean that the claim is fraudulent. An exaggeration of a claim may amount to fraud if it is dishonestly made or so greatly in excess of the true amount as to be incompatible with good faith or that the exaggeration or over-estimation of loss was so serious as to lead to the inference that the insured must have intended to defraud the insurer (paras 26, 27 & 36)

(2) The relevant date for ascertainment of the amount of loss or claim in a fire insurance claim is the date of the loss. In insurance law, a fire policy is an indemnity policy, that is, a policy which obligates the insurer only to make good the actual loss suffered by the insured. The insured cannot recover more than the sum insured under the policy. (para 38)

(3) The adjuster's report clearly indicated that the insured's claim was exaggerated or grossly inflated. By making an application to amend its statement of claim, by relying on the amount of losses as stipulated in the adjuster's report, the insured was in agreement with, and had accepted, the content of the adjuster's report. The fraudulent intent on the part of the insured could properly be inferred from the conduct of the insured in deliberately and intentionally inflating the claim to deceive the insurer. The material time in establishing the exaggeration or fraudulent intent on the part of the insured was when it made its initial claim to the insurer on 24 June 2013, and not at the time when

A the claim was filed in the court or after its statement of claim was amended before the trial started. That was the time when the fundamental premise of good faith on the part of the insured collapsed and the whole sub-strata of the claim under the policy fell. (paras 44 & 45)

B **(4)** The Court of Appeal correctly applied the law in concluding that the exaggeration of the claim amounted to fraud, as the insured had failed to rebut the presumption that it was not acting in good faith. The insured had made a false statement in its claims lists with the knowledge that it was false. Hence, the entire claim was liable to be defeated on the C ground that the insured failed to exercise good faith. The insured, having made a total claim knowing it to be false, could not recover a partial loss even if the policy applied to the loss that had happened. (paras 47 & 48)

(5) Insurance claim is an action based on contract. Following the definition under s. 17 of the Contracts Act 1950, there was sufficient evidence to D show the insured, with the intent to deceive the insurer, had committed acts falling within paras. (a), (b), (c) and (d) of s. 17 in attempting to inflate or exaggerate the claims. Fraud can either be proved by direct evidence or by an inference based on the facts and surrounding circumstances of the case. Therefore, in answering the questions, it was E held that, where an exaggerated insurance claim for a larger amount was made by an insured, fraud or fraudulent intent could properly be inferred at law based on the facts and surrounding circumstances of the case which, by virtue of the conditions of claim in a policy, would entitle the insurer to repudiate liability. The standard of proof in F insurance claims is on the balance of probabilities. (paras 50, 52 & 54)

Bahasa Malaysia *Headnotes*

Perayu ('pengambil insurans'), yang memiliki dan mengusahakan bengkel membaiki kereta, mengambil polisi insurans kebakaran yang ditawarkan oleh responden ('syarikat insurans'), bertajuk 'Motor Repairers Protection G Plan Policy' ('polisi'), yang berkuat kuasa dari 20 Disember 2012 hingga 19 Disember 2013. Polisi tersebut memperuntukkan, antara lain, perlindungan insurans jika berlaku kebakaran di bengkel itu dengan jumlah maksimum yang diinsuranskan sebanyak RM1.4 juta. Pada 21 Mei 2013, kebakaran berlaku di bengkel dan memusnahkannya dan beberapa barangan H yang diinsuranskan. Pengambil insurans memohon pampasan kerugian bawah polisi tersebut daripada syarikat insurans. Pada 24 Julai 2013, pengambil insurans mengemukakan tuntutan berjumlah RM1,699,850 ('tuntutan pertama'). Walau bagaimanapun, pada hari berikutnya, pengambil insurans mengemukakan tuntutan terpinda kepada syarikat insurans. I Kerugian tidak dinyatakan. Kemudian, pada 9 Julai 2013, pengambil

insurans mengemukakan tuntutan yang disemak berjumlah RM1,712,560 untuk kesemua kerugian dan kerosakan yang dialami akibat kebakaran tersebut ('tuntutan yang disemak'). Syarikat insurans, melalui surat bertarikh 4 Mac 2014, menolak liabiliti atas alasan tuntutan pengambil insurans dinaikkan secara melampau dan tercemar oleh penipuan. Oleh itu, pengambil insurans memfailkan tuntutan terhadap syarikat insurans di Mahkamah Tinggi. Walau bagaimanapun, sejurus sebelum perbicaraan bermula, pengambil insurans, dengan kebenaran mahkamah, meminda pernyataan tuntutannya dengan menyertakan tuntutan untuk jumlah RM237,452.11 sahaja untuk seluruh kerugian dan kerosakan yang dialami akibat kebakaran itu untuk menggambarkan kerugian yang dinilai oleh pelaras yang dilantik syarikat insurans. Mahkamah Tinggi membenarkan tuntutan tersebut dan memerintahkan syarikat insurans membayar jumlah RM237,452.11. Berikutan rayuan oleh syarikat insurans, Mahkamah Rayuan mengakas dan mengetepikan keputusan Mahkamah Tinggi dan memutuskan bahawa syarikat insurans berhak menafikan liabiliti dan menolak polisi insurans kebakaran atas alasan tuntutan itu dilebih-lebihkan dan palsu. Oleh itu, pengambil insurans diberi kebenaran merayu ke Mahkamah Persekutuan atas soalan-soalan berikut: (i) apabila pengambil insurans memfailkan tuntutan untuk jumlah yang lebih besar, dan pliding dipinda untuk mengurangkan tuntutan, tanpa penipuan sebenar, sama ada syarikat insurans masih berhak menolak liabiliti atas alasan tuntutan yang melampau; dan (ii) apabila dakwaan 'tuntutan melampau/dinaikkan', dibuat, sama ada penipuan sebenar (dari segi kontrak), perlu dibuktikan, dalam cara biasa, oleh orang yang menyatakannya.

Diputuskan (menolak rayuan dengan kos)
Oleh Ramly Ali HMP menyampaikan penghakiman mahkamah:

(1) Polisi insurans kebakaran, sebagai kontrak insurans, bersifat '*uberrimae fidei*', iaitu, kontrak dengan keyakinan penuh. Kontrak itu memerlukan standard kejujuran tinggi antara pihak-pihak. Kesemua pihak yang berkenaan mesti berurusan secara jujur, membuat perisytiharan penuh tentang kesemua fakta penting, khususnya apabila membuat tuntutan sewajarnya untuk kerugian dan kerosakan bawah polisi apabila berlaku kebakaran. Apabila pengambil insurans dinaikkan atau melebihkan tuntutannya, terdapat anggapan *prima facie* bahawa dia tidak bertindak jujur dan pengambil insurans perlu mematahkan anggapan itu jika hendak berjaya dalam tuntutannya. Beban menunjukkan bahawa tuntutan tersebut adalah palsu terletak pada syarikat insurans. Fakta bahawa satu-satu tuntutan adalah melampau atau dinaikkan tidak semestinya bermaksud tuntutan tersebut palsu. Satu tuntutan yang melampau boleh membentuk penipuan jika dibuat secara tidak jujur atau

melampaui jumlah sebenar secara berlebihan sehingga menjadi bertentangan atau tuntutan berlebihan atau kerugian yang ditaksir secara berlebihan adalah terlalu serius sehingga menjurus pada inferens bahawa pengambil insurans mempunyai niat menipu syarikat insurans.

(2) Tarikh relevan untuk menentukan jumlah kerugian atau tuntutan dalam tuntutan insurans kebakaran ialah tarikh kerugian tersebut. Dalam undang-undang insurans, polisi kebakaran ialah polisi perlindungan, iaitu, polisi yang mewajibkan syarikat insurans memampas hanya kerugian sebenar yang dialami oleh pengambil insurans. Pengambil insurans tidak boleh mendapatkan semula lebih daripada jumlah yang diinsuranskan bawah polisi.

(3) Laporan pelaras jelas menyatakan bahawa tuntutan pengambil insurans amat berlebihan atau dinaikkan secara melampau. Dengan memohon untuk meminda pernyataan tuntutan bersandarkan pada jumlah kerugian yang dinyatakan dalam laporan pelaras, pengambil insurans menyetujui dan menerima kandungan laporan pelaras. Niat untuk menipu oleh pengambil insurans boleh disimpulkan daripada tindakan pengambil insurans yang sengaja dan dengan niat menaikkan tuntutan untuk menipu syarikat insurans. Masa penting untuk membuktikan tuntutan melampau dibuat atau niat menipu oleh pengambil insurans ialah semasa tuntutan awal pada 24 Jun 2013, dan bukan semasa tuntutan difailkan di mahkamah atau selepas pernyataan tuntutannya dipinda sebelum permulaan perbicaraan. Itu adalah masa apabila asas kejujuran pada pihak pengambil insurans runtuh dan keseluruhan sub-strata tuntutan bawah polisi tersebut gagal.

(4) Mahkamah Rayuan mengguna pakai undang-undang dengan betul dalam memutuskan bahawa tuntutan yang dilebih-lebihkan itu membentuk penipuan, kerana pengambil insurans gagal mematahkan anggapan bahawa pengambil insurans tidak bertindak dengan jujur. Pengambil insurans membuat kenyataan palsu dalam senarai tuntutannya dengan pengetahuan bahawa kenyataan itu palsu. Oleh itu, keseluruhan tuntutan wajar ditolak atas alasan pengambil insurans gagal bertindak dengan suci hati. Selepas membuat tuntutan keseluruhan dengan pengetahuan bahawa tuntutan itu palsu, pengambil insurans tidak boleh mendapatkan semula sebahagian kerugian walaupun polisi tersebut diguna pakai pada kerugian yang dialami.

(5) Tuntutan insurans adalah tindakan berdasarkan kontrak. Berikutan definisi s. 17 Akta Kontrak 1950, terdapat keterangan yang mencukupi untuk menunjukkan pengambil insurans, dengan niat menipu syarikat insurans, telah melakukan tindakan-tindakan yang terangkum dalam perenggan (a), (b), (c) dan (d) s. 17 dalam mencuba untuk menaikkan

atau melebih-lebihkan tuntutan. Penipuan boleh dibuktikan sama ada dengan keterangan langsung atau melalui inferens berdasarkan fakta dan hal keadaan sekeliling kes. Oleh itu, dalam menjawab soalan-soalan tersebut, diputuskan bahawa apabila tuntutan insurans yang melampau untuk jumlah yang lebih besar dibuat oleh pengambil insurans, niat menipu boleh disimpulkan dari segi undang-undang berdasarkan fakta-fakta dan hal keadaan sekeliling kes yang, melalui syarat-syarat tuntutan dalam polisi, akan memberi hak kepada syarikat insurans untuk menolak liabiliti. Standard pembuktian dalam tuntutan insurans adalah atas imbangan kebarangkalian.

Case(s) referred to:

AXA General Insurance Ltd v. Gottlieb [2005] 1 All ER (Comm) 445 ***(refd)***
Britton v. Royal Insurance Company (1865) 4 F & F 905 ***(refd)***
Castellain v. Preston [1883] II QBD 380 ***(refd)***
Dome Mining Corporation, Ltd v. Drysdale [1931] 41 Lloyd's Rep 109 ***(refd)***
Galloway v. Guardian Royal Exchange (UK) Ltd [1997] All ER (D) 14 ***(refd)***
Globe Trawlers Pte Ltd v. National Employers Mutual General Insurance Association Ltd & Anor [1989] 1 CLJ 831; [1989] 2 CLJ (Rep) 924 HC ***(refd)***
Lek v. Mathews [1927] 29 LIL Rep 141 ***(refd)***
Leppard v. Excess Insurance Co Ltd [1979] 1 WLR 512 ***(refd)***
Levy v. Baillre [1831] 7 Bing 349 ***(refd)***
Manifest Shipping Co Ltd v. Uni-Polaris Shipping Co Ltd & Others [2003] 1 AC 469 ***(refd)***
Meacock v. Byrant & Co [1942] 2 All ER 661 ***(refd)***
Orakpo v. Barclays Insurance Services and Another [1995] LRLR 443 ***(refd)***
Richard Aubrey Film Production Ltd v. Graham [1960] 2 Lloyd's Rep 101 ***(refd)***
Sinnaiyah & Sons Sdn Bhd v. Damai Setia Sdn Bhd [2015] 7 CLJ 584 FC ***(refd)***
Tiep Thi Ho v. Australian Associated Motor Insurers Ltd [2001] VSCA 48 ***(refd)***
Versloot Dredging BV and another v. HDI Gerling Industrie Versioherung AG and Others [2016] UKSC 45 ***(refd)***
West Wake Price & Co v. Ching [1956] 2 All ER 821 ***(refd)***
Wong Cheong Kong Sdn Bhd v. Prudential Assurance Sdn Bhd [1998] 1 CLJ 916 HC ***(refd)***

Legislation referred to:

Contracts Act 1950, s. 17(a), (b), (c), (d)

Other source(s) referred to:

SH Noakes, *Welford & Offer-Barry's Fire Insurance,* 4th edn, p 289

For the appellant - GK Ganesan, CC Lam & Sharavenan; M/s Dave Anan
For the respondent - Gurmukh Singh & Theebadarshini; M/s Isharidah Ho Chong & Menon

[Editor's note: For the Court of Appeal judgment, please see AXA Affin General Insurance Bhd v. ALW Car Workshop Sdn Bhd [2017] 2 CLJ 163 (affirmed).]
[For the High Court judgment, please see [2015] 1 LNS 1095 (overruled).]

Reported by S Barathi

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JUDGMENT

Ramly Ali FCJ:

Introduction

[1] The appellant in this appeal, ALW Car Workshop Sdn Bhd (the insured) is appealing against the decision of the Court of Appeal dated 13 April 2016 in deciding that the respondent, AXA Affin General Insurance Berhad (the insurer) was entitled to deny liability and repudiate the fire-policy insurance on a claim submitted by the insured on the ground that the claim was exaggerated and fraudulent.

[2] The insured filed its claim in the High Court at Kuala Lumpur. The claim was allowed. On appeal to the Court of Appeal by the insurer, the decision was reversed and set-aside; and judgment was entered in favour of the insurer.

Brief Facts

[3] The insured, at all material time, owned and operated a car repair workshop in Malacca. The insured had taken a fire insurance policy offered by the insurer, entitled "Motor Repairers Protection Plan Policy" (the policy). The effective duration of the policy was from 20 December 2012 to 19 December 2013. It provides, among others, insurance coverage in case of fire to the workshop with a maximum insured sum of RM1.4 million.

[4] On 21 May 2013 (at about 8.40pm) a fire broke out at the workshop and destroyed the workshop and some of the insured items. The insured sought indemnity for the losses from the insurer under the policy. On 24 June 2013, the insured submitted a claim amounting to RM1,699,850 (the first claim). On the next day (25 June 2013) the insured submitted an amended claim to the insurer. Losses were not quantified. Later (on 9 July 2013) the insured submitted a revised claim amounting to RM1,712,560 for all the losses and damage suffered due to the fire (the revised claim). By a letter dated 4 March 2014, the insurer repudiated liability on the grounds that the insured's claim had been grossly exaggerated and tainted with fraud.

[5] The reasons for the repudiation of liability were detailed by the insurer as follows:

(i) most of the 69 vehicles claimed as 'customers' vehicles' were in doubt because these vehicles did not have valid insurance policies;

(ii) the insured had submitted false claims in respect of a few vehicles which were not affected or damaged by the fire;

(iii) some of the vehicles were claimed as being in normal working condition were observed to have violent accident wreckage marks;

(iv) there were vehicles devoid of ownership details;

(v) exaggerated claims were made for several vehicles which were in fact in a crumpled/wrecked state prior to the fire; and

(vi) at least three vehicles were falsely claimed as 'customers' vehicles' when in fact the insured had purchased them as scrap/wreck from the insurers of those vehicles.

[6] The insured filed its claim against the insurer at the High Court. Just before the trial started, with leave of the court, the insured amended its statement of claim, to include a claim for the sum of RM237,452.11 only for the total loss and damage suffered due to the fire to reflect the losses assessed by the adjuster appointed by the insurer.

[7] On 13 May 2015, the learned Judicial Commissioner (JC) allowed the insured's claim and ordered the insurer to pay a sum of RM237,452.11 (as claimed) and interests at 5% p.a. from 21 May 2013 until the date of its full payment. In coming to that decision, the learned JC made the following findings:

> that the defendant (the Insurer) was not able to prove that:
>
> (i) the Insured has the intention to defraud in making a claim in this case;
>
> (ii) the Insured has actual knowledge that it has suffered no loss and damage;
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> (iii) the Insured has actual knowledge that the claim was false;
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> (iv) the Insured has actual knowledge that the claim was supported by the use of fraudulent means or devices;
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> (v) the Insured has actual knowledge that the claim was supported by false evidence; and
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> (vi) the Insured has actual knowledge that the claim was exaggerated or inflated.

[8] The learned JC concluded:

> In view of the above decision that the defendant has failed to prove that the plaintiff had made a fraudulent claim in this case, I find that the plaintiff has not breached an implied duty under the Policy to act in utmost good faith.

[9] On appeal to the Court of Appeal by the insurer, the appeal was allowed and the decision of the learned JC was reversed and set aside. Briefly, the Court of Appeal ruled as follows:

> [39] The central issue in this appeal relates to the question whether the claims of the plaintiff are fraudulent within the meaning of Condition 3 of the Claims Conditions. It is abundantly clear that the plaintiff's claim as contained in the two claims lists are exaggerated for the reasons adverted to in para 14(i)-(vii) above.

A [40] On the totality of evidence, we do not agree with the findings of the learned JC which is against the weight of the evidence. We have perused the appeal record and are unable to find any evidence to rebut the presumption that the plaintiff is not acting in good faith. On the contrary, SP1 admitted under cross-examination that there were a number of vehicles which did not sustain any damage but B were nevertheless declared as damaged. Whilst exaggeration in itself is not automatically fraud, but that in many cases a fraudulent intent can properly be inferred from the representation of a deliberately inflated claim … We are, therefore, constrained to hold that the plaintiff had made a false statement in the claim lists with the knowledge that is false.

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[41] In the light of our findings, the entire claim is liable to be defeated on the ground that the plaintiff failed to exercise good faith in its dealings with the defendant. It must follow that since the plaintiff made a total claim knowing it to be a false claim, the plaintiff cannot later recover for a partial loss even if the Policy applies to the loss D that has happened (*Dome Mining Corp Ltd v. Drysdale* [1931] 41 Lloyds's Rep. 109; *Re Carr (supra)*). Accordingly, it will not avail the plaintiff to argue that its claim on the figure of RM237,451.11 advised by the adjusters should be allowed.

[10] The reasons adverted to in para 14(i)-(vii) in the Court of Appeal's E judgment are as follows:

14. First, the following findings by the adjusters were never challenged by the plaintiff. As such the plaintiff's claim for the loss of 69 customer vehicles held in trust is tainted with fraud for the following reasons:

F (i) the owners of 20 vehicles (item nos. 2, 10, 11, 13, 14, 18, 20, 22, 23, 25, 26, 27, 31, 34, 38, 41, 42, 44, 48 & 62) could not be located at the given addresses;

(ii) 9 of the vehicles (item nos. 3, 4, 5, 8, 9, 17, 27, 50 & 59) had in fact been sold by the owners to the plaintiff as scrap; as such G these 9 vehicles were not customer vehicles held in trust;

(iii) 4 of the vehicles (item nos. 12, 16, 19 & 66) were add by the owners to other second hand dealers;

(iv) One vehicle (item no. 30) was in fact a stolen vehicle which had been handed to the financiers;

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(v) 27 of the vehicles in question (item nos. 3, 5, 8, 9, 10, 11, 12, 13, 14, 16, 17, 18, 19, 20, 21, 23, 26, 30, 31, 32, 33, 34, 38, 39, 41, 42 & 69) were falsely misrepresented to be in Excellent-Good-Fair condition but the vehicles in question were in fact crumpled beyond economic repair;

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(vi) 10 vehicles (item nos. 25, 45, 46, 47, 51, 59, 61, 66, 67 & 68) were falsely misrepresented as being damaged in the fire but discovered to have not sustained any damage; and

(vii) Only 6 of the vehicles in question were confirmed by the adjusters to be customers' vehicles held in trust and in an acceptable condition pre-fire and sustained *bona fide* damage.

[11] Dissatisfied with the decision of the Court of Appeal, the insured filed an appeal to this court. Hence the present appeal before us.

[12] On 7 December 2017, this court granted the insured leave to appeal on the following questions:

(i) where an insurance claim filed for a larger amount, and pleadings are amended to reduce the claim, in the absence of actual fraud, whether the insurer is still entitled to repudiate liability on the basis of an exaggerated claim; and

(ii) where an allegation of an 'exaggerated/inflated claim', is made, ought actual fraud (in the contractual sense) be proven, in the usual way, by those who allege it?

Submissions By The Insured's Counsel

[13] The insured's case is that an exaggerated claim was extinguished and erased by an amendment to the statement of claim allowed by the court just before trial started on the principle that the amendment relates back to the date of the statement of claim was first filed in the action, and therefore a presumption of fraud cannot be drawn against a plaintiff who had filed an exaggerated claim. Learned counsel submitted that there is no authority to support the creation of a 'presumption' of fraud. The law in the UK and Malaysia has always been clear that the party alleging fraud must prove it and the exaggeration, whilst indicative of fraud, is not in and of itself fraud. In this case, the amendment was made to match the amount stated in the adjuster's report which was only disclosed to the insured just before the trial.

[14] Learned counsel contended that since the amendment to the statement of claim relates back to the time of the filling of the writ and statement of claim, the court and the parties must treat the case as if the appellant had always, *ab initio*, made a claim for RM237,452.11 as reported by the adjuster and not any larger sum; therefore any allegation of exaggerated claim was extinguished by the amendment; thus once such an amendment has been allowed by the court, the element of exaggerated claim will cease to exist and the insurer, as an opposing party, when it did not challenge the amendment by way of an appeal, cannot then rely on it to invoke a defence of exaggerated claim.

[15] Learned counsel further contended that an inflated or exaggerated claim does not *ipso facto* give rise to a presumption of fraud. To create a presumption of fraud, which is what the Court of Appeal has done in this case, sets a dangerous precedent. It is a departure from the accepted principle that a 'mere inflation' of an insurance claim will not in and of itself be fraudulent. A claim larger than what is assessed by the insurer's adjuster is not fraudulent unless it is accompanied by an 'intent to deceive' the insurer to induce it to enter into a contract; and by creating a presumption of fraud in cases where claims are larger, the Court of Appeal has circumvented the statutory requirements of the Contracts Act 1950.

[16] In para. 21 of his written submissions, learned counsel submitted:

> The issue before this court is whether something more must be shown, apart from a difference in the quantum claimed by the Insured and the quantum assessed by the Insurer's adjusters, in order for the court to come to the finding that a fraudulent claim had been made. We think so. Intent must be proven as well. Any insurer seeking to repudiate liability on the grounds of a fraudulently exaggerated claim must prove that the difference in the sum claimed by the insured and the sum assessed by the insurer was made with the intent to deceive the insurer into paying a larger sum than what is due.

[17] In the present case, learned counsel argued that the insured did not make its claim with any dishonesty or intent to deceive the insurer. The 'exaggeration' in the claim was a result of the insured's classification of the damaged vehicles as 'vehicles held on trust' as opposed to 'stock in trade'; the trial judge found that this difference in classification was born out of a genuine lack of understanding of legal terms and not out of deceit. It was also argued that at all material times, the insured worked together with the insurer's adjusters and allowed them to have access to its premises and documents; the adjusters had the opportunity to make their own investigation, and indeed to advise the insured of the difference between 'vehicles held on trust' and 'stock in trade', but chose not to. There is no dispute that the risk insured against did actually occurred and that the insured had suffered the sort of losses and damage that was insured against.

Submissions By The Insurer's Counsel

[18] Learned counsel for the insurer submitted that from the decision of the Court of Appeal where it was held that the insured's claim was exaggerated with knowledge that the same was inflated, a fraudulent intent could be inferred. The claim was reduced on the day of the trial to 80%-90% less than what was attempted to be claimed from the insurer initially; hence it is indisputable that the claim submitted to the insurer was grossly and manifestly exaggerated.

[19] Learned counsel argued that an insurance policy under which the present claim arises is a specific type of contract; hence the same is governed by the Contracts Act 1950. "Fraud" is defined in s. 17 of the Contracts Act 1950; the section does not allude to the phrase "actual fraud" as used by the insured in its question posed before the court. The insured had submitted false statement in the claims as ruled by the Court of Appeal with the knowledge that it was false and that satisfied the "actual fraud". The decision of the Court of Appeal is therefore in tandem with s. 17 of the Contracts Act 1950. The Court of Appeal ruled that there were fraudulent statements made *vide* the claims lists submitted by the insured; and that was an outright and active perpetration of fraud where the same was in consonance with both statute as well as cl. 3 of the claims conditions appearing in the policy.

[20] It was also submitted by learned counsel that it is trite that notwithstanding the sudden drastic reduction of the figures claimed, the insured did attempt to defraud the insurer at the time when the claim was submitted to the insurer; hence the Court of Appeal correctly decided that the insured was in breach of the principle *"uberrimae fidei"*. Hence, the contention of the insured which in effect is that it is entitled to be excused simply because of a drastic amendment adopting the adjuster's figures is misplaced.

[21] On this issue, learned counsel submitted that the first question posed should be answered in the affirmative ie, an insurer is entitled to repudiate a claim and sustain its repudiation, regardless of amendments to the figures claimed at the trial, where it is established that the insured breached the duty of *"uberrimae fidei"* or breached the condition of the policy governing submission of a claim in any way fraudulent.

[22] On the issue as to whether fraud should be proved "in the usual way" or not, learned counsel contended that the matter is already settled, thus not novel citing this court's decision in *Sinnaiyah & Sons Sdn Bhd v. Damai Setia Sdn Bhd* [2015] 7 CLJ 584. Learned counsel submitted that in civil cases where fraud is the subject of the claim, the standard of proof is on the balance of probabilities. The principle is also in line with the provisions of s. 17 of the Contracts Act 1950.

Our Decision

[23] In this appeal, we are dealing with a matter of fire insurance claim by an insured, where an insurer had repudiated liability pursuant to the terms and conditions of the policy on the ground that the claim was exaggerated and/or fraudulent.

[24] An insurance policy is a contract between an insured and an insurer. In simple language, it is an arrangement by which an insurer undertakes to provide a guarantee of compensation for specified losses or damage against a possible eventuality, in return for payment of a specified premium by the insured.

[25] Fire insurance specifically is property insurance covering damage and losses suffered by an insured caused by fire. The insurer agrees to indemnify the insured for the financial loss which the latter may suffer due to destruction of or damage to property or goods caused by fire during a specified period. The contract as found in the policy specified the maximum amount, agreed to by the parties at the time of the contract which the insured can claim in case of loss. The insurer is liable to make good the claim not exceeding the maximum amount specified based on the strict compliance with the terms and conditions of the policy.

[26] The fire insurance policy, being a contract of insurance is of a nature known as contract *"uberrimae fidei"*, that is a contract of fullest confidence. It requires the highest standard of good faith between the parties. All parties concerned must deal in good faith, making a full declaration of all material facts, particularly in making an appropriate claim for loss and damage under the policy when an event of fire occurred.

[27] At the pre-contract stage, there is a positive duty on the part of the insured to disclose all information which is material to the risk proposed and the assessment of the premium. At the post-contract stage, ie, after the issuance of the policy, the insured is duty-bound to reveal all facts which the insurer might have an interest in knowing and which might affect his conduct. When a claim is made under the policy, the insured's duty is one of honesty and required that the claim is not made fraudulently and the insured is not in breach of the duty to observe the utmost good faith. That duty applies at the stage when the insured filed its initial claim to the insurer. Once the parties are engaged in litigation in court, the rationale of good faith no longer applies because the parties are governed by the rules of court (see: *Manifest Shipping Co. Ltd v. Uni-Polaris Shipping Co. Ltd & Others* [2003] 1 AC 469).

[28] As ruled by Lord Woolf MR in *Galloway v. Guardian Royal Exchange (UK) Ltd* [1997] All ER (D) 14, citing the well-known textbook of *Welford & Offer-Barry's Fire Insurance,* 4th edn, by SH. Noakes, at p. 289, "since it is the duty of the assured to observe the utmost good faith in his dealings with the insurers throughout, the claim which he puts forward must be honestly made; and if it is fraudulent, he will forfeit all benefit under the policy whether there is a condition to the effect or not."

[29] In another case, *Orakpo v. Barclays Insurance Services and Another* [1995] LRLR 443, Hoffmann LJ said: A

> The relevant principle is stated as follows by Malcolm Clark in his book, The Law of Insurance Contracts [1989], at p. 434 …
>
> This proposition is supported by both principle and authority. In principle insurance is a contract of good faith. I do not see why the duty of good faith on the part of the assured should expire when the contract has been made. The reasons for requiring good faith continue to exist. Just as the nature of the risk will usually be within the peculiar knowledge of the insured, so will circumstances of the casualty, it will rarely be within the knowledge of the insurance company. I think that the insurance company should be able to trust the assured to put forward a claim in good faith. Any fraud in making the claim goes to the root of the contract and entitles the insurer to be discharged.

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[30] In his judgment in *Galloway (supra)* Lord Woolf MR also stressed that "I would take the view that the consequences are that the view of the judge was right and the whole of the claim was thus tainted by fraud. The position is that the contract remains one of good faith and the insured is required to exercise good faith in the making of the claim. In the making of the claim the facts are normally wholly within the insured's knowledge. The insurers are dependent on the insured exercising good faith in order to evaluate the claim." D

E

[31] The issue of fraudulent claim clause (as found in the policy) was a subject of discussion by the House of Lords in the case of *Lek v. Mathews* [1927] 29 LIL Rep 141, where Lord Sumner at p. 145 of the report had clearly explained as follows: F

> As to the construction of the false claim clause, I think that it refers to anything falsely claimed, that is, anything not so unsubstantial as to make the maxim *de minimis* applicable, and is not limited to a claim which as to the whole is false. It means claims as to particular subject-matters in respect of which a right to indemnity is asserted, not the mere amount of money claimed without regard to the particulars or the contents of the claim; and a claim is false not only if it is deliberately invented but also if it is made recklessly, not caring whether it is true or false but only seeking to succeed in the claim.

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[32] Willes J, in his summing up to the jury in the case of *Britton v. Royal Insurance Company* (1865) 4 F. & F. 905, said the following words: H

> If the claim is fraudulent, it is defeated altogether. That is, suppose the insured made a claim for twice the amount insured and lost, thus seeking to put the office off its guard, and in the result to recover more than he is entitled to, that would be a willful fraud, and the consequence is that he could not recover anything.

I

> The contract of insurance is one of perfect good faith on both sides, and it is most important that such good faith should be maintained. It is the common practice to insert in fire policies conditions that they shall be void in the event of a fraudulent claim; and there was such a condition in the present case. Such a condition is only in accordance with legal principle and sound policy. It would be most dangerous to permit parties to practice such frauds, and then, notwithstanding their falsehood and fraud, to recover the real value of the goods consumed. And if there is willful falsehood and fraud in the claim, the insured forfeits all claim whatever upon the policy.

[33] The above principle was adopted and applied by the King's Bench Division in the case of *Dome Mining Corporation, Ltd. v. Drysdale* [1931] 41 Lloyd's Rep. 109 where Justice Branson ruled as follows:

> If, therefore, it is established that the plaintiffs made their claim for a total loss either knowing that the claim was false or recklessly without an honest belief in its truth, the policy is avoided, and the defendant is not liable thereunder, though actually some substantial loss may have been suffered by the plaintiffs by the perils insured against.

[34] Insurance fraud happens when the insured deceives or defrauds the insurer in order to obtain a higher amount of compensation under the policy. Common insurance fraud activities include exaggerated estimates of losses or damage, under reporting important information, and making false claims.

[35] Whether a particular insurance claim is tainted with a fraudulent intent is largely a question of fact to be inferred from the surrounding circumstances. As allegations of fraud are normally made by the insurer, the onus is on the insurer to show that a particular claim made by the insured is fraudulent. An insured who is making a fraudulent claim often exaggerates the amount of the insured items that he has at the time of the loss.

[36] When an insured inflates or exaggerates his claim, there is a *prima facie* presumption that he is not acting in good faith and it is for the insured to rebut the presumption if he is to succeed in his claim (see: *Levy v. Baillre* [1831] 7 Bing 349). The onus of showing that a claim is fraudulent lies with the insurer. When an exaggerated or inflated claim is put forward by the insured, it is quite easy for the insurer to establish an intention on the part of the insured to defraud the insurer unless the insured is able to give reasonable explanation as to why he had put forward the exaggerated or inflated claim. The mere fact that a claim was exaggerated or inflated does not necessarily mean that the claim is fraudulent. It is for the insurer alleging that the claim is fraudulent to show that the claim has been exaggerated or inflated by the insured with the view to defraud the insurer (see: *Globe Trawlers Pte. Ltd v. National Employers Mutual General Insurance Association Ltd & Anor* [1989] 1 CLJ 831; [1989] 2 CLJ (Rep) 924; [1989] 1 MLJ 463).

[37] A claim or statement made by the insured is fraudulent if he knows it to be false and makes it in order that the insurer may act on it. An exaggeration of a claim may amount to fraud if it is dishonestly made or so greatly in excess of the true amount as to be incompatible with good faith or that the exaggeration or over-estimation of loss is so serious as to lead to the inference that the insured must have intended to defraud the insurer. The surrounding circumstances, in making the claim must point towards such an inference of the intention to defraud (see: *Wong Cheong Kong Sdn Bhd v. Prudential Assurance Sdn Bhd* [1998] 1 CLJ 916).

[38] It is trite law that the relevant date for ascertainment of the amount of loss or claim in a fire insurance claim is the date of the loss. In insurance law, a fire policy is an indemnity policy, that is, a policy which obligates the insurer only to make good the actual loss suffered by the insured. The insured cannot recover more than the sum insured under the policy. The insured cannot recover more than what he establishes to be the actual amount of his loss (see: *Wong Cheong Kong Sdn Bhd (supra)*; *Meacock v. Byrant & Co.* [1942] 2 All ER 661; and *West Wake Price & Co. v. Ching* [1956] 2 All ER 821; *Richard Aubrey Film Production Ltd. v. Graham* [1960] 2 Lloyd's Rep 101).

[39] This principle had been clearly laid down by Brett LJ in *Castellain v. Preston* [1883] II QBD 380. We can do no better on this point than to quote the speech of Megaw LJ in the English Court of Appeal case of *Leppard v. Excess Insurance Co. Ltd* [1979] 1 WLR 512, where His Lordship cited *Castellain v. Preston (supra)*, at p. 518:

> Ever since the decision of this court in *Castellain v. Preston* [1883] 11 QBD 380, the general principle has been beyond dispute. Indeed, I think it was beyond dispute long before *Castellain v. Preston*. The insured may recover his actual loss, subject, of course, to any provision in the policy as to the maximum amount recoverable. The insured may not recover more than his actual loss. As it was put by Brett LJ in *Castellain v. Preston*, at p. 386:
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> > In order to give my opinion upon this case, I feel obliged to revert to the very foundation of every rule which has been promulgated and acted on by the courts with regard to insurance law. The very foundation, in my opinion, of every rule which has been applied to insurance law is this, namely, that the contract of insurance contained in a marine or fire policy is a contract of indemnity and of indemnity only, and that this contract means that the assured, in case of a loss against which the policy has been made, shall be fully indemnified, but shall never be more than fully indemnified. That is the fundamental principle of insurance, and if ever a proposition is brought forward which is at variance with it, that is to say, which either will prevent the assured from obtaining a full indemnity, or which will give to the assured more than a full indemnity, that proposition must certainly be wrong.

[40] Where a claim has been fraudulently exaggerated, the insured's dishonesty is calculated to get him something to which he is not entitled. The reason why the insured cannot recover even the honest part of the claim is that the law declines to sever it from the invented part. The policy of deterring fraudulent claims goes to the honesty of the claim, and both are parts of a single claim. (See: *Versloot Dredging BV and another v. HDI Gerling Industrie Versioherung AG and Others* [2016] UKSC 45; *Galloway v. Guardian Royal Exchange (UK) Ltd (supra)*; and *AXA General Insurance Ltd. v. Gottlieb* [2005] 1 All ER (Comm.) 445 (CA) para 31).

[41] In *Tiep Thi Ho v. Australian Associated Motor Insurers Ltd* [2001] VSCA 48, Buchanan JA delivering judgment at the Victoria Court of Appeal (Australia) stated that the mischief of the fraudulent claims rule lay in the insured's dishonest state of mind and not in its consequence. At para. 14 of the judgment, His Lordship put the matter thus:

> As a matter of public policy, attributable to the need to promote honesty on the part of insured persons and proponents for insurance, whose knowledge of the relevant circumstances of the casualty as well as the nature of the risk was generally greater than that of their insurers, the courts would not aid a fraudulent claimant. The courts would not look behind fraud to see if otherwise there was a valid claim or a claim unaffected by the fraud, and no effort was made to reduce or extinguish claims only after gauging the effects of the fraud upon insurers.

[42] In the present appeal before us, the insurer repudiated the claim submitted by the insured on the strength of condition 3 of the general conditions in the policy in question ie, Fire Insurance Policy No. SMO/0334891/33/12/AW, which states:

> If the claim be in any respect fraudulent, or if any false declaration be made or used in support thereof, or if any fraudulent means or devices are used by the Insured or any one acting on his behalf to obtain any benefit under this Policy; or if the loss or damage be occasioned by willful act, or with the connivance of the Insured; or if the claim be made and rejected and an action or suit be not commenced within three (3) months after such rejection, or in the case on an Arbitration within three (3) months after the Arbitrator or Arbitrators or Umpire shall have made their award, all benefit under this Policy, shall be forfeited.

[43] It must be noted, from the evidence available, that the initial claim made by the insured on 24 June 2013 was for a sum of RM1,699,850 (as per particulars set out in the claim). On 9 July 2013 the insured submitted a revised claim to the insurer for an increased sum of RM1,712, 560 (as per particulars in the revised list). Finally, the insured's claim was revised again and this time, reduced to RM237,452.11 just before the trial started in the High Court on 4 February 2015 by way of an amendment to its statement of claim to reflect the actual losses assessed by the adjuster as stated in the adjuster's report. The report and findings of the adjuster were never challenged by the insured.

[44] In fact, by making an application to amend its statement of claim by relying on the amount of losses as stipulated in the adjuster's report, the insured was in agreement with and had accepted the content of the adjuster's report which in essence states that the claim for the loss of 63 customer vehicles held in trust was tainted with fraud.

[45] The adjuster's report clearly indicated that the insured's claim was exaggerated or grossly inflated. The facts and surrounding circumstances of the case clearly indicated that fraudulent intent on the part of the insured can properly be inferred from the conduct of the insured in deliberately and intentionally inflating the claim to deceive the insurer. The material time in establishing the exaggeration or fraudulent intent on the part of the insured was when it made its initial claim to the insurer on 24 June 2013, not at the time when the claim was filed in court or after its statement of claim was amended before trial started. That was the time when the fundamental premise of good faith on the part of the insured collapsed and the whole substrata of the claim under the policy fall. The amendment to the statement of claim, made just before the trial started in court, was nothing more than a mere afterthought on the insured's part. It cannot repair the damage done.

[46] On this point, we agree with the Court of Appeal in its findings, as stated in para. [33] of its judgment, that:

> Whether any particular claim is tainted with fraudulent intent is a question of fact to be inferred from the surrounding circumstances. Making a false statement in the belief that it is true constitutes misrepresentation. However, making a false statement with the knowledge that it is false or not believing it to be true and the intention to deceive amounts to fraudulent misrepresentation. The test of fraudulent misrepresentation as enunciated by the Privy Council in *Baron Akerheilm v. Rolf De Marc* [1959] AC 789 PC is as follows:
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> > The question was not whether the defendant in any given case honestly believed the representation to be true in the sense assigned to it by the court on an objective consideration of its truth or falsity, but whether he honestly believed the representation to be true in the sense which he understood it *albeit* erroneously, when it was made.

[47] The Court of Appeal had correctly applied the law (with which we agree) in concluding that the exaggeration of the claim in the present case amounted to fraud, as the insured had failed to rebut the presumption that it was not acting in good faith. We also agree with the Court of Appeal that the insured had made a false statement in its claims lists with the knowledge that it was false.

[48] The Court of Appeal had also applied the correct principles of law (with which we agree), as earlier discussed in this judgment, in concluding that:

A In the light of our findings, the entire claim is liable to be defeated on the ground that the plaintiff failed to exercise good faith in its dealings with the defendant. It must follow that since the plaintiff made a total claim knowing it to be a false claim, the plaintiff cannot later recover for a partial loss even if the Policy applies to the loss that has happened (*Dome Mining Corp Ltd. v. Drysdale* [1931] 41 Lloyd's Rep. 109; and *Re Carr (supra)*). Accordingly, it will not avail the plaintiff to argue that its claim on the figure of RM237,451.11 advised by the adjusters should be allowed.

[49] The second question posed relates to the standard of proof required in establishing 'fraud' in civil cases, ie, whether 'actual fraud' (in the C contractual sense) must be proven, in the usual way, by the insurer who alleged it.

[50] Insurance claim is an action based on contract. It relates to a contract or an agreement in the form of the policy entered into between the insured and the insurer. Therefore, in dealing with such a contract, the Contracts Act D 1950 (the Act) applies.

[51] Section 17, of the Act defines 'fraud' as follows:

"Fraud" includes any of the following acts committed by a party to a contract, or with his connivance, or by his agent, with intent to deceive E another party thereto or his agent, or to induce him to enter into the contracts:

(a) the suggestion, as to a fact, of that which is not true by one who does not believe it to be true;

(b) the active concealment of a fact by one having knowledge or belief F of the fact;

(c) a promise made without any intention of performing it;

(d) any other act fitted to deceive; and

(e) any such act or omission as the law specially declares to be G fraudulent.

[52] It must be noted that the provisions do not allude to the phrase "actual fraud", as used by the insured in its second question before the court. In the present case, we had earlier, in agreeing with the Court of Appeal, concluded and ruled that the insured had submitted a false statement in its claim which H amounted to an exaggerated fraudulent claim on the policy. Following the definition under s. 17 of the Act, there is sufficient evidence to show the insured, with intent to deceive the insurer, had committed acts falling within paras. (a), (b), (c) and (d) of s. 17 in attempting to inflate or exaggerate the claims. Our decision as well as the decision of the Court of Appeal in this I matter are therefore in tandem with the definition of 'fraud' under s. 17 of the Act. Fraud can either be proved by direct evidence or by an inference based on the facts and surrounding circumstances of the case.

[53] On the issue of standard of proof in proving 'fraud' in civil cases, we find that the matter is already settled in law. It is not a novel issue. This court in *Sinnayah & Sons Sdn Bhd v. Damai Setia Sdn Bhd (supra)* has put the issue at rest. In that case, Richard Malanjum CJ (Sabah & Sarawak) (as His Lordship then was), delivering the judgment of the court, made the following ruling:

> The correct principle to apply is as explained in *In re B (Children)* where it was stipulated that at law, there are only two standards of proof, namely beyond reasonable doubt for criminal cases and on the balance of probabilities for civil cases. As such, even if fraud is the subject in a civil claim, the standard of proof is on the balance of probabilities. There is no third standard. Therefore, it is up to the presiding judge, after hearing and considering the evidence adduced as being done in any other civil claim, to find whether the standards of proof has been attained.

Conclusion

[54] Based on the applicable principles of law as discussed above in this judgment and our agreement with the findings of the Court of Appeal on this matter, we will answer both the questions posed in this appeal in the following manner:

> Where an exaggerated insurance claim for a larger amount is made by an Insured, fraud or fraudulent intent can properly be inferred at law based on the facts and surrounding circumstances of the case which by virtue of the Conditions of Claim in a Policy would entitle the Insurer to repudiate liability. As in all other civil cases where fraud is the subject of the claim or defence, the standard of proof in insurance claims is on the balance of probabilities.

[55] In the upshot, we dismiss the appeal with costs. We affirm and uphold the decision of the Court of Appeal.